MARYLAND PSYCHOTHERAPY CENTER, LLC
www.mdtherapycenter.com

NEW CLIENT INFORMATION

Date: _____

Client's Name: _____

Client's Date of Birth: _____

Client's Address: _____

_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Email Address:_____
Is it okay to leave messages at the above phone numbers or email address for correspondence related to therapy services, appointments, or billing? (Please specify which numbers and/or email address you would me to leave messages on.)

_____

Single____ Married_____ Other_____
Spouse/Partners name: _____

Name/Age of Children_____

_____

Client's Occupation: _____

Current Medications: _____

_____

Person to Notify in the event of an emergency: _____

Relationship: _____

Home phone: _____Work phone: _____Cell phone_____
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Have you received previous counseling or psychological care? _____ If so, by whom & when?

_____

Please add any other information you think might be helpful including family history of mental disorders or medical problems and reason for coming.

_____

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How did you hear about this practice?

_____